

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.  
24065

SEP 28 1927

1. PLACE OF DEATH  
County Irene Registration District No. 318  
Township Springfield Primary Registration District No. 2001  
City Springfield (No. 1858 N. Roberson) Sl. 483 Ward

2. FULL NAME Pauline Schuler  
(a) Residence. No. 1858 N. Roberson St.  Ward.   
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX. Female  
4. COLOR OR RACE white  
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 11 - 1854

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
72 9 20

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work House Wife  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Va.

10. NAME OF FATHER Rudolph Mers

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER Anna Collins

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Va.

14. INFORMANT A. Schuler  
(Address) Springfield, Mo.

15. FILED 8/1 27 Oct 27 1927  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 1 1927

17. I HEREBY CERTIFY That I attended deceased from July 17 1927 until July 31 1927 that I last saw her alive on July 31, 1927, and that death occurred, on the date stated above, at 5:30 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:  
Organic Heart  
(duration) 1 yrs.  mos.  da.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH. no

DID AN OPERATION PRECEDE DEATH. no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) J. G. Crows, M.D.  
Aug 1, 1927 (Address)

State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL  
Eastview Cemetery Aug 2 1927

20. UNDERTAKER ADDRESS  
J. W. Klingner & Co., 414 E. Court  
Springfield, Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Excise

of interest in the property of

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Greene

Registration District No. 318

File No. \_\_\_\_\_

Township \_\_\_\_\_

Primary Registration District No. 2001

Registered No. 483

City Springfield (No. \_\_\_\_\_)

St. \_\_\_\_\_

Ward) \_\_\_\_\_

**2. FULL NAME**

Pauline Schuler

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward. \_\_\_\_\_

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) \_\_\_\_\_

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. \_\_\_\_\_

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work \_\_\_\_\_

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_

(STATE OR COUNTRY) \_\_\_\_\_

10. NAME OF FATHER \_\_\_\_\_

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_

(STATE OR COUNTRY) \_\_\_\_\_

12. MAIDEN NAME OF MOTHER \_\_\_\_\_

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_

(STATE OR COUNTRY) \_\_\_\_\_

14.

INFORMANT \_\_\_\_\_

(Address) \_\_\_\_\_

15.

FILED 8/1/27

October 27

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 1 27

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, (that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Organic heart  
vascular insufficiency

CONTRIBUTORY (SECONDARY) \_\_\_\_\_

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_

IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.

, 19 (Address) \_\_\_\_\_

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL \_\_\_\_\_

DATE OF BURIAL \_\_\_\_\_

19

20. UNDERTAKER \_\_\_\_\_

ADDRESS \_\_\_\_\_

Every item of information should be carefully supplied. A FE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very largely important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY

SUPPLEMENTARY

24065